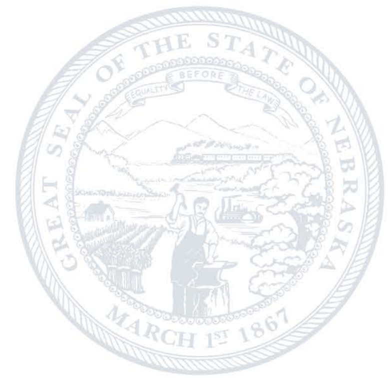
NEBRASKA

Good Life. Great Opportunity.

Department of Insurance



Pete Ricketts, Governor

NR-1701

Media Contact:
Peg Jasa, Maggie Dolezal - 402-471-2201

FOR IMMEDIATE RELEASE

Process for Appealing a Health Plan Decision

March 1 - (Lincoln, NE) – It is important for all Nebraskans to know they have the right to appeal a denied health insurance claim. Insurers **must** explain why they've denied a claim or ended an insured's coverage, and they have to let insureds know how their decisions can be disputed. "While this process may not be applicable to the individual situations of all Nebraskans, it does provide the opportunity for appropriate issues to be brought to the attention of an independent reviewer," said Director of Insurance Bruce Ramge.

There are two stages to the process for appealing a health plan decision. The first stage is the Internal Appeals process. If a claim is denied or health insurance coverage is cancelled, insureds have the right to an internal appeal. To file an internal appeal, all forms required by the health insurer must be completed, or write to the insurer and provide the insured's name, claim number, and health insurance ID number. Also, any additional information the insurer should consider may be submitted to explain why it is believed the company's decision was wrong. A letter from the insured's doctor, for example, would be helpful. An internal appeal must be filed within 180 days (6 months) of receiving notice that the claim was denied. If the insured has an urgent health situation, an external review can be requested at the same time as the internal appeal.

The second stage to appeal a health plan decision is External Review. Claims that were denied services based on medical necessity, appropriateness, health care setting, level of care, effectiveness or treatments considered to be experimental or investigational are types of denials that can be accepted for External Review. An insured has four months from the date a denial notice was received to request external review. The insurer will provide the insured with the external review request form. The form can also be obtained from **doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Chapter87ExternalReviewForms.pdf** on the Department of Insurance website. Instructions for submitting the external review request are included on the form.

If the insured has an urgent health situation, an Expedited External Review may be submitted. This review takes 72 hours to be completed. A standard external review can take up to 45 days. An expedited review would be appropriate if the timeframe for the standard external review seriously jeopardizes the life or health of the insured or jeopardizes the insured's ability to regain maximum function.

More information can be found in a brochure on the Department of Insurance website at **doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/AppealingAHealthPlanDecisionRevised.pdf**.

###